Michigan Department of Community Health Bureau of Health Systems Division of Licensing and Certification

FACILITY INFORMATION SHEET

To ensure the accuracy of facility information in the database and to ensure that licenses contain accurate information, this facility form must be submitted for each licensed facility. DO NOT send with the invoice (see page 2).

Section 1: Facility Information		
1. Facility Name:	2. Facility Address:	
3. Facility Phone Number:	4. CCN/Medicare Provider #: 23-	
3. Facility Friorie Number.	4. CON/Medicale Flovider #. 25	
	National Provider Identifier (NPI) #:	
Facility Fax Number:		
Section 2: Administrator Informat	ion	
Administrator Name:		
2. Phone Number:		
3. E-mail Address:		
Section 3: Ownership (legal entity which directly owns the facility):		
1. Licensee/Owner of Facility:	2. Federal Tax ID Number:	
Section 4: Accreditation		
Is your facility Medicare certified? yes no		
Has the facility been granted "deemed status" by CMS by means of an accrediting organization such		
as JC, AAAHC, AAAASF, AOA, CHA		
If yes, list accrediting organization: _		
Expiration date of accreditation :		
Attach a copy of your approval letter.		
Authority: P.A. 368 of 1978 as amended	The Michigan Department of Community Health will not discriminate against any	
Completion: Mandatory	individual or group because of race, sex, religion, age, national origin, color,	
BHS-LC-101 (Rev. 7/08) Page 1 of 2	marital status, disability, or political beliefs. You may make your needs known to this agency under the <i>Americans with Disabilities Act</i> if you need assistance with	

reading, writing, hearing, etc.

Section 5: Licensed Beds (hospital and hospice residence only)

I. Medical/surgical			
1. ICU 2. Rehab			
3. Other 4. Swing			
(total of 1, 2, 3 and 4 must match medical/surgical total)	Total Medical/Surgical Beds		
II. Pediatric 1. NICU 2. Non-NICU peds (total of 1 and 2 must match pediatric total)	Total Pediatric Beds		
III. Obstetrical	Total Obstetrical Beds		
Total Facility Beds (excluding psych beds)			
IV. Hospice Residence 1. Hospice Residence beds 2. LTC licensed-only hospice beds			
Total Hospice Residence Beds			
Section 6: Certification by Applicant			
The Administrator certifies that the information provided is true, complete and accurate to the best of his/her			
knowledge. Administrator Signature:	Date:		
Transmittation digitation.	Dato.		

This form should <u>not</u> accompany the invoice. Send to the Division of Licensing and Certification:

MDCH Bureau of Health Systems Division of Licensing and Certification PO Box 30664 Lansing, MI 48909

fax (517) 241-3354

email: DCH-BHS-L&C@michigan.gov

Contact (517) 241-4160 with any questions.